

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9899-61-039318
STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. _____

AMENDED

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 5 days	c. CITY OR TOWN Clayton Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Little Rock Hospitals, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 31 Hillvale Drive Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Hillel Middle - Last Unterberg, M.D.	4. DATE OF DEATH Month October Day 25 Year 1961
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-8-81	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months 0 Days 17	IF UNDER 24 HR Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Neurologist		10b. KIND OF BUSINESS OR INDUSTRY Medical Profession		11. BIRTHPLACE (City and state or country) Cleveland, Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Arthur Unterberg	13b. MOTHER'S MAIDEN NAME Francis Bear	14. NAME OF HUSBAND OR WIFE Donna Trask Unterberg
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI	17. INFORMANT Address Donna Trask Unterberg, 31 Hillvale Dr.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Coronary artery disease DUE TO (c) 4201		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 3 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Oct 20-61 to Oct 25-61 and last saw him alive on Oct 24, 1961 Death occurred at 1.45 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE L. B. Harrison (Degree or title) M.D.	22b. ADDRESS 1755 So. Grand	22c. DATE SIGNED 10-25-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept. 27, 1961	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR ADDRESS Robt. Ambruster 6633 Clayton St. Louis	25. DATE RECD. BY LOCAL REG. OCT 26 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

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Licensed Embalmer No. 1788

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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